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BULLETIN of the
MENNINGER CLINIC

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TRAINING IN PSYCHIATRIC SOCIAL WORK

By MARGARET J. WILLIAMS*

Psychiatric social work is the practice of social work in connection with psychiatry. Training in this field, therefore, addresses itself to the adaptation of basic social work and especially basic case work knowledge and skill to the understanding and treatment of the social factors in psychiatric problems. Training for practice in this specialty differs from training for case work in non-psychiatric agencies only as this is indicated by the introduction of function of the psychiatric agency, illness of the patient, and cooperative work with other professions. Of paramount importance is the unification (by all available teaching devices) of the ways of thinking about and feeling about people emerging from courses in psychiatry, case work and field work. Training in its final form becomes a way of thinking about human beings combined with specific professional disciplines which enable the practitioner to be used as a facilitating force in the patient's struggle for self-realization.

Content and standards of training described in this paper are essentially those which have been determined by the American Association of Psychiatric Social Workers and are maintained by the fifteen schools of social work which offer training in psychiatric social work†. Training, as in other fields of social work, consists of two years of graduate training leading to the Master's degree. The first, or basic year, includes field work which is usually in a family agency and course content in a variety of subjects including case work, group work, medical information, psychiatric information, public welfare, community organization and social research as prescribed by the American Association of Schools of Social Work.

The second year is one of specialization with the field work in a psychiatric agency and most of the courses have to do with psychiatric understanding of individuals and the development of skill in the application of that understanding to the practice of social case work in the various psychiatric settings. There is a minimum core of required courses in all

* Assistant Professor of Social Work, George Warren Brown School of Social Work, Washington University, St. Louis, Missouri.

† American Association of Psychiatric Social Workers, "Curriculum in Psychiatric Social Work," (unpublished), December 13, 1943.

the schools and most of the schools have added a number of courses in order to broaden and intensify the knowledge and skill of students.

Course Content

In addition to electives and required courses in other areas of knowledge important to all social workers, there is a minimum requirement for course content in five subjects in the psychiatric social work curriculum. These minimum areas of knowledge are as follows:

Psychopathology, which covers the severe neuroses, mental deficiency, convulsive disorders, psychosomatic conditions and the more specific psychoses, both organic and functional. This material is presented from the point of view of motivations of behavior, its meaning to the individual, with emphasis upon the differences as well as the similarities in normal and abnormal behavior. It is fully understood that the student's grasp of this material as well as that discussed later under dynamics of behavior will be only partial. For effective teaching all this material must be reviewed, emphasized and applied repeatedly in case work classes in relation to offering services to individuals having these conditions. The curricula in the various schools are planned from the point of view that consecutive courses in these subjects as well as others added by individual schools will deepen and enrich the understanding and use of this knowledge from the field of psychiatry. There is some discussion of current practices in hospitals and clinics with reference to administrative procedures and treatment procedures such as psychotherapy, shock therapy, hydrotherapy, occupational therapy, recreational therapy and the relative merits of these with various conditions. The desired method of teaching this material is a combination of lecture and discussion with clinic observation. It is essential that the psychiatrist teaching this content be one who has a dynamic approach to the study and treatment of personality problems in order to facilitate the student's ready integration of this knowledge with the point of view about people gained in the various case work courses and in the other courses in psychiatry.

Dynamics of Personality covers the normal emotional development of human beings with the ways in which deviations occur. Attention is focused upon the normal development in infancy, childhood, adolescence, adulthood and old age. There is emphasis upon the various mechanisms which individuals employ to achieve emotional balance. Likewise, there is emphasis upon the inter-relation of emotional, intellectual, physical and social factors in various age levels and in various personality patterns.

Courses in *Health and Disease* cover the common illnesses, symptomatology, treatment and their social implications for individuals. This subject matter is designed to familiarize the social work student with norms of

physical growth and to develop a readiness on the part of the student to search for the inter-relation of physical and emotional difficulties. In this area of study as in advanced courses of psychiatry introduced by certain schools, there is increasing emphasis upon recent findings from psychosomatic medicine and the social implications of these.

A course in *Mental Testing* is required of all psychiatric social work majors who have not previously had a course in mental testing and is elective for those who have had such a course. It is a general orientation course given not to enable students to give psychometric examinations, but to enable them to better understand the significance of tests, and to become familiar with the psychologist's function and contribution in cooperative work. Students are expected to gain some general knowledge of modern theories of intellectual development and of norms of intellectual functioning for various age levels and they are expected to gain an understanding of factors that must be considered in testing the emotionally disturbed person.

Course content in *Psychiatric Social Work* covers a discussion of the various settings in which the psychiatric social caseworker operates and the specific nature of his contribution within these respective settings.

Students are given specific instructions in the purposes, organization and methods of functioning in child guidance clinics, children's psychiatric study homes, various psychiatric clinics for adults, consultation centers in army camps, psychiatric units in schools, day nurseries and industrial set-ups, psychiatric wards in general hospitals and mental hospitals including those under auspices of municipalities, states and the Federal government. Through this course content the student increases his knowledge and skill in case work service to patients having various kinds of mental and emotional illness. He learns the differences and the peculiar adaptations of social case work introduced by the function of the psychiatric agency, the mental or emotional illness of the patient, and the fact of the social worker's acting as a member of a group of persons representing different professions all serving the same patient. Probably schools of social work will find it increasingly important to give attention to inter-professional working relationships considering how psychiatrist, nurse, psychologist, social worker and others of the treatment team can work together most effectively to insure minimum waste of professional energy and maximum achievement in service to each patient.

Emphasis is placed upon the distinct differences which exist and the unique contributions and methods existent in social case work in contrast with psychotherapy. Along with full awareness of the inter-relation of social and emotional factors—the two can never be separated—the social worker's approach in most cases is first to that part of the problem which is more social than emotional.

Case work records are used to illustrate treatment of different kinds of psychiatric problems from various types of agencies. As stressed above, training is most effectively pursued when there is integration of theory presented in the class room with field work practice. In a number of schools this integration is augmented by class discussion of cases from the student's field practice. Some schools arrange their programs to permit the member of the faculty teaching courses in psychiatric social work to also maintain a schedule of periodic conferences with the field work student and his supervisor to insure maximum integration of the didactic material with the day-to-day practice.

In addition to the above basic courses considered essential, most of the schools have found it possible to offer a large number of additional courses on various subjects including child psychiatry, advanced psychopathology, advanced psychotherapeutic theory, psychosomatic medicine and advanced courses in psychiatric social case work with children, with adolescents and with patients in various other psychiatric settings.

Research

The student does a piece of research on some aspect of psychiatric social work for the twofold purpose of giving him practical experience in methods of social research and to further increase the body of knowledge in this field. The research project is carried on under the supervision of the member of the school faculty responsible for research with a member of the psychiatric social work faculty serving as consultant.

Field Work

Throughout training, field work provides continuous opportunity for: (a) increasing knowledge about people, how they live, the problems they face in adjustment to living and aids in evolving a point of view about people which recognizes the dynamic and changing quality of human life; (b) extension and refinement of skills in case work treatment by repeated experience in practice under supervision; and (c) acquisition of knowledge and skill in matters of administration of the social service department within the hospital or clinic, as well as in the community at large. Thus, field work, as a prominent and integral part of the total training, provides continuous increase in knowledge and skill and at its conclusion constitutes a final testing ground for the student's professional competence.

Regardless of the agency in which the student has his field work placement there are five chief areas of case work service (implicit under *b* in the paragraph above) in which he should have repeated experience under close supervision. These are: (a) the social study as an aid in determing diagnosis, prognosis, and treatment; and as an evaluation of resources and lia-

bilities in the patient and his family, friends, and community; (b) interpretation of the patient, his illness and treatment to the family to insure their maximum cooperation and casework service to the family to preserve and develop attitudes and activities conducive to the patient's current and future mental health; (c) case work service to members of his family to help them cope with their own social and emotional problems created by the illness of the patient; (d) case work treatment of the patient to assist him to greater understanding and ability in dealing with the more social aspects of psychiatric problems which often involve his concern about family, employment, or the use of various treatment facilities; and (e) interpretive and referral service as well as concurrent cooperative casework with other social agencies and community services.

Students majoring in psychiatric social work must in no instance have less than six hundred clock hours of supervised field work in a psychiatric setting and this must cover a minimum of six consecutive months in one psychiatric agency. This follows the basic year of training. The specialized field work usually exceeds the minimum of six hundred clock hours covering a span of time of six months inasmuch as many of the schools have arranged for their students to have placements from nine to twelve months in which they complete a total of hours of field practice considerably in excess of the minimum. Each student's field work practice is closely supervised by a social worker who preferably is a member of the American Association of Psychiatric Social Workers and one who has demonstrated personal and professional capacity necessary for a field instructor in psychiatric social work. Although field instructors may be members of the school faculty they are usually staff members of the agency assuming responsibility for field instruction. Irrespective of this there must be joint selection of the field instructor by the agency and the school and in the instance of the supervisor from the agency staff, there must be assurance of sufficient freedom from other responsibilities to permit adequate uninterrupted teaching time. Usually the field instructor devotes from four to five hours per week to the training of one student. This time is devoted to individual conferences with the student, to the study of his current case records and in planning for supervisory conferences. Additional time is required for other matters relevant to the student's training such as conferences with the director of the social service department, with the psychiatrist in charge of the service, in attendance at case conferences, and in the selection of cases to be assigned to the student. In addition to supervision by the social work field instructor, it is essential that the student and supervisor have periodic consultation on the student's work by the psychiatrist who has over-all responsibility for the treatment of each patient.

Supplementary Training

Graduates of accredited schools of social work who have had training in some phase of case work other than psychiatric social work may take prescribed supplementary work and thereby qualify as having completed training in psychiatric social work and become eligible for membership in the professional association. This additional training consists of a minimum of six hundred clock hours of supervised field work in a psychiatric agency plus courses in psychiatric social work, psychopathology and other courses, as indicated by the school offering training, in advanced psychiatry and advanced case work.

Schools

Historically, training in psychiatric social work is recent. In 1914, Dr. E. E. Southard, Miss Mary C. Jarrett, and others of the staff of Boston Psychopathic Hospital initiated apprentice training and gave courses in psychiatry and psychiatric social work at the Simmons College School of Social Work. Following this, Dr. Southard and Miss Jarrett participated in the establishment of a training course in psychiatric social work at Smith College in 1918*. In the years that have followed during which other schools have developed training, content and goals of this training have seen many changes. Throughout, but probably now more than at any previous period, the pressing need is more good field work facilities. In July 1947 the American Association of Psychiatric Social Workers employed an educational secretary,† thereby assuming more decided responsibility for professional preparation for practice in psychiatric social work.

Following is a list of schools of social work in which the educational program for psychiatric social work has been approved by the Committee on Professional Education of the American Association of Psychiatric Social Workers:

Boston University, School of Social Work, Boston, Mass.

University of California, Department of Social Welfare, Berkeley, Calif.

Catholic University of America, School of Social Work, Washington, D. C.

University of Chicago, School of Social Service Administration, Chicago, Ill.

* French, Lois Meredith, *Psychiatric Social Work*, New York, The Commonwealth Fund, 1940. Chap. 2, p. 40.

† Inquiries regarding training may be addressed to Miss Madeleine Lay, Educational Secretary, American Association of Psychiatric Social Workers, 1790 Broadway, New York, or any one of the fifteen schools with approved curricula.

New York School of Social Work, New York City, N. Y.
Pennsylvania School of Social Work, Philadelphia, Pa.
University of Pittsburgh, School of Social Work, Pittsburgh, Pa.
Simmons College School of Social Work, Boston, Mass.
Smith College, School for Social Work, Northampton, Mass.
University of Minnesota, School of Social Work, Minneapolis, Minn.
Tulane University of Louisiana, School of Social Work, New Orleans, La.
University of Southern California, School of Social Work, Los Angeles, Calif.
Washington University, George Warren Brown School of Social Work, St. Louis, Mo.
Wayne University, School of Public Affairs & Social Work, Detroit, Mich.
Western Reserve University, School of Applied Social Sciences, Cleveland, Ohio

THE PSYCHIATRIC SOCIAL WORKER IN THE MENTAL HOSPITAL

Conclusions and Recommendations: Report of the Committee on Psychiatric Social Work, Group for the Advancement of Psychiatry, Minneapolis, Minn., June 28 to 30, 1947.

In preparing for this report, the Committee sent questionnaires to 34 psychiatrists over the country, representing mental hospitals of every kind, state, veterans', and private, requesting them to sit down with mental hospital people in their area, superintendents and staff, medical and social work, and to send us the results of their discussions on present practices and desirable changes. Replies were received from 27 of the 34, reporting on the current status of social work in well over 100 mental hospitals and presenting a great many fruitful and challenging ideas for the fuller utilization of social work skills in mental hospital practice. As the replies came in, a series of meetings, 14 in all, were held by Committee members and experts in the New York area, abstracting and co-ordinating the large mass of material. The conclusions and recommendations therefore embody the thinking not only of the Committee and its staff of experts, but also of more than 300 psychiatrists and psychiatric social workers with extensive experience in mental hospitals in all parts of the country.

It is of interest to note that the profession of psychiatric social work had its origin in the mental hospital. The earliest provisions for the inclusion of social work as a function of mental hospital service occurred in 1906 in Manhattan State Hospital in New York and in 1910 at the Boston Psychopathic Hospital. The psychiatric social work program at Smith College School of Social Work was not established until 1918, that at the New York School of Social Work not until 1919. While the over-all field of social work has since made enormous strides in the achievement of professional clarification and status, social work in the mental hospital has lagged far behind, stultified in its development by a parallel failure of mental hospital psychiatry to keep pace with progress in its own field.

Discussion of the place which psychiatric social work should assume in the mental hospital rests upon a number of basic concepts concerning the function of the mental hospital itself. In the first place, the Committee considers that the treatment of the mentally ill is primarily a community responsibility, and that the hospital is a treatment facility of the community, rather than its dump-pile for the disposal of human wreckage. The goal of treatment is seen as return to community living, with the fullest utilization of all medical resources for the personal, social and vocational rehabilitation of the patient. Finally, treatment in the hospital is regarded as a total institutional process, rooted in medical responsibility,

but with the psychiatrically oriented participation of every staff member, each contributing to the total process on the basis of clearly established administrative allocations of responsibility and of well-grounded and disciplined professional attitudes.

The social case worker deals with a wide range of social and personal problems. To enumerate them would be to name the whole gamut of human ills, failure and frustration, such as unemployment, poor housing, need for money, need for medical care, need for help in planning care of children, need for help with disturbed inter-personal relationships. In order to help people who at least momentarily are unable to cope with their own affairs, the social case worker must know the tensions in their lives. He must know what can be done about them and how they can be changed. He must also understand what the person feels, how he deals with his feelings, and how his way of responding serves him in the light of his present life pressures, past experience and future aspirations. It is only with this understanding of the person and of what his problems mean to him in his present life situation that environmental stresses may be effectively modified and the individual's participation engaged in the recovery of self-reliance.

Whether the individual's social problem originates in the external situation or within himself, in either instance the social case worker may be called upon to render services which meet practical reality needs. When these services are rendered in relation to feelings and ways of responding, they may ease anxieties, relieve discouragement, give new confidence, and enable the individual to manage his affairs more competently. Along with or apart from these actual concrete types of services, the case worker may help the person in the following ways:

a) by helping him to clarify his indecision, or to discharge feelings and also to understand feelings which are obstructing constructive action or inducing destructive behavior;
b) by helping him to understand his situation better;
c) by helping other people significant in his life.

The major areas of learning which the social case worker must experience, assimilate and integrate are:

a) knowledge and understanding of normal human behavior;
b) considerable knowledge and understanding of psychopathology;
c) an understanding of the interplay of family life and its import for the individual;
d) an understanding of community life and its impact on the individual and his family;
e) a comprehensive acquaintance with community resources and skill in using them in service to an individual and his family;

f) an understanding of the helping relationship and its management. This implies understanding what taking help commonly means to people and becoming acquainted with the various ways in which clients need to use the relationship. It implies also considerable self understanding in order that the social case worker may regulate his own feelings and objectify his own emotional need so that the persons dependent upon him for help may derive strength rather than be weakened through the relationship.

All this makes necessary, in addition to certain content of knowledge, an orderly way of thinking which is attained through study and supervised practice. It implies also a way of feeling about people and their problems which is attained through the knowledge imparted and the discipline developed in professional education.

A psychiatric social worker is a social case worker, who is practicing in a psychiatric setting. Beyond the basic preparation which every social case worker has, the psychiatric worker will have attained through clinical training:

1) More comprehensive knowledge and a deeper understanding of psychopathology; of differential diagnosis; and of treatment appropriately geared to this.
2) A modification of his function in relation to that of others in the clinical team, hence a greater knowledge of the function and ways of working in related professional groups.

In this setting he will not ordinarily be expected to undertake the resolution of deep psychopathological conflicts. His contribution to therapy will usually primarily lie in his understanding of human inter-relationships and the strengthening of the healthy aspects of the patient's personality by helping him adjust to reality problems.

Social Work in Hospital Administration

Social work should operate as a specifically designated administrative department with a director of social work responsible to the clinical director, or in hospitals where there is no such position, on an adminstrative level which provides direct liaison with the superintendent of the hospital. This administrative provision should require the inclusion of the director of social work in administrative staff meetings and participation in discussions of hospital policies which pertain to the treatment and welfare of patients. The responsibility of social service to administration cannot be fully met if the director of the social service department functions on a less well-defined basis. The practice of social workers being "called on," developing a "close relationship," or attending "informal or formal meetings" does not promote the desired administrative relationship. For

continuity and effectiveness, especially in the event of changing personnel, a clearly defined administrative structure is considered essential.

The development by the medical staff of a positive attitude towards social work will depend on their knowledge of the content of professional social work training and on their previous experience in professional interrelationship with social workers in clinics, social agencies and mental hospitals.

Adequate funds are essential to the development and maintenance of professional standards in any social work program. Specifically, items requiring budgetary provision should include sufficient private interviewing space, transportation, communication, secretarial service, clerical service, provisions for social work students, funds for social service exchange, and a social service library.

Functions of Psychiatric Social Work in the Mental Hospital

General: Because of inadequate administrative clarification of his function, the utilization of the social worker is often ineffective, inappropriate and economically wasteful. For example, psychiatric social workers are often used for a variety of clerical and messenger details, for which no professional training is actually required, or they are asked to do psychological testing, for which they have had no training. Then again, there is a tendency for social service to be used too much in out-patient activities and insufficiently for services to patients in the hospital.

It is recommended that the utilization of social services be limited to properly defined case work functions, and that case work activities be integrated into the total program of hospital treatment.

Intake is the studied and differential process of making hospital services available to persons in the community who can benefit by hospital care, and as such it is almost non-existent in present-day mental hospital practice, except in the rare instances where traveling clinics carry out such functions.

It is recommended that intake as defined is an essential aspect of mental hospital practice, and one in which the psychiatric social worker has important responsibilities in relation to the following:

a) the interpretation of the hospital's facilities and program to the patient;

b) assistance to the family with problems arising from the patient's admission to the hospital, amelioration of family anxieties in relation to the threat of having a mentally ill relative, interpretation to the family of the hospital's treatment procedures;

c) formulation of plans, with the assistance of other community social agencies, which might make admission less urgent or occasionally prevent unnecessary or ill-advised admissions.

d) establishing a relationship with the family which will enable them to maintain a positive, non-rejecting attitude throughout the period of care, and ultimately helping them to receive the returning patient with understanding and acceptance.

Reception is the process of helping the patient to accept his hospitalization, of relieving the fears and threats inherent in the experience of compulsion and restraint, of allowing him to respond to the therapeutic potentialities of living experienced under psychiatric supervision and direction.

It is recommended that the social work function in reception should include the following:

a) explanation, repeated as often as is necessary, of all routine hospital and medical procedures;

b) helping the patient to understand that the worker represents his link to the hospital staff on the one hand, and his family and the community on the other, and that his present and past interests and ties will be carefully safeguarded and preserved.

The Treatment Program. Since the concept of treatment as a total integrated institutional experience should be stressed, the social worker must be concerned with every aspect of his patient's relationships within the hospital as well as to family and community. Such activity on the part of the social worker reaffirms the idea that the hospital's responsibility is limited in time to a period of more specialized treatment, and that treatment carries over into the community. The use of the term "preparing the home" is inappropriate since it implies a previous surrender of family responsibility, and it is the clear-cut function of the social worker to prevent any such disruption in the continuity of the family-patient relationship. For the family, the mentally ill patient often becomes a frightening stranger. The worker can help the family with this problem of disturbance of familiarity so that they can accept him back on whatever level they find him. In such social work activity there is real promise of reducing length of hospital stay as well as avoiding a good deal of unnecessary human suffering.

It is agreed that a treatment plan is shaped by a process of changing formulation of the illness. The psychiatrist may delegate responsibility, and may utilize the skill of the psychiatric social worker both in direct and in indirect work with the patient. Individual professional contributions hould be confined to the competence which is derived in the particular professional training. As stated above, the psychiatric social worker's contribution in the mental hospital, derives especially from his understanding of inter-personal relationships and from his ability to strengthen the healthy aspects of the patient's personality by helping him deal with reality problems.

Pre-convalescence. Pre-convalescent care should be an integral part of the treatment process within the hospital. The activity of the psychiatric social worker in assuming a professional responsibility under the aegis of mental hospital administration insures that the hospital administration recognizes its continuing responsibility to the community from which it derives its function. This will facilitate the integration of mental hospital services with the general and specific needs of the community in relation to psychiatric problems.

Family Care, which is the placement of patients with families other than their own for care and treatment, is recognized as a major development in the care of mental patients. It is deplorable that this extremely promising procedure has not been more widely employed. It is deplorable that patients who assist in the maintenance of the institution are often denied the benefits of family care.

The responsibility for selection of patients for family care and their medical supervision while under such care belongs entirely to the psychiatrist. The responsibility for finding a suitable home, for interpreting the patient and his needs to the foster family, for maintaining proper standards of care, and for helping the patient to adapt to his new situation, belongs entirely to the social worker. There is no other professional group qualified by training and experience to assume this responsibility.

After Care is the re-establishment of the patient in the community. During the period of after care the patient remains a responsibility of hospital authorities. The social worker assists in the discharge of hospital responsibility by exercising continued supervision of the patient and by attempting to make available to the patient all possible community resources which might help in his readjustment. Furthermore, the social worker's awareness of inter-personal relationships may prevent the endangering of the mental health of others in the family.

Social History. It is vital that the social history be considered as a constantly reformulated body of information. It consists of material revealed as an outgrowth of a purposeful relationship of the psychiatric social worker with the patient, members of his family, physicians and agencies acquainted with the patient, and other community resources with which the patient may have had some experience or which may be helpful in future planning. This dynamically developed social history provides the foundation for a continuing relationship of the psychiatric social worker to the patient and his family and community, within the total treatment process, and also makes a very important contribution to total treatment itself.

Education and training. The primary educational responsibility of the social work department is toward students of social work and social work

apprentices. The specific content of the educational and training program should be determined by the social service department in conformity with administrative policy. Such training requires adequate personnel to carry on the regular social work duties of providing service to patients as well as the educational program.

Psychiatric social workers should contribute to the education of psychiatric internes and residents in order to broaden their orientation in the following areas: inter-personal relationships of parents and children; social and economic stresses in their impact upon the family life of the patients; the availability of social, health, employment, recreational, educational, vocational, legal and other community resources.

In the education and training program within the hospital for other non-social work personnel, it is the specific responsibility of the social worker to interpret the content of his own professional activities.

The recruiting, screening, training and assignment of all volunteers is the responsibility of the clinical director who may delegate these functions to the heads of the departments to which volunteers are assigned. Those assigned to the social service department become the direct responsibility of the chief social worker.

Research. There are two main areas of research which should be of interest to the psychiatric social worker in a mental hospital. The first is the participation in projects developed by the medical staff, related to the total hospital program. Follow-up studies of various groups of patients belong to this type of research, as do studies in social pathology. The second is the evaluation of the effectiveness of the activity of the social work department, such as the refinement of procedures in case work, and exploring trends in community relations affecting mental health.

Community Interpretation. The duties and responsibilities of the social worker, both in the hospital and in the community, place him in a very advantageous position to develop constructive attitudes toward the recognition and treatment of mental illness, and to secure the participation of lay groups in the development of favorable attitudes toward mental hospital care. With mental patients continually returning to the community, there is real and urgent need for an informed public to develop awareness, acceptance and understanding of these patient's problems.

It is therefore recommended that adequate time be allotted to the psychiatric social worker for community interpretation.

Personnel Practices and Standards

Formulated personnel practices. Professionally accepted personnel practices, stating policies relating to classification and salary scales, increments, vacations, educational leave, attendance at professional conferences, in-

surance and retirement plans, contracts, evaluation and provision for review are basic to a sound relationship between social work staff and hospital administration. There should be a manual in which these personnel practices are specifically stated.

Qualifications

The following qualifications are recommended for psychiatric social work positions in mental hospitals:

1. *Staff workers.* Psychiatric social work positions in mental hospitals should require graduate professional training in a recognized school of social work with a major emphasis in psychiatric social work. Where less than fully trained personnel have to be used in social service departments, it is recommended that they be designated by a completely different title which distinguishes them from professionally trained psychiatric social workers. Experience in this sub-professional position should not qualify an apprentice for a psychiatric social work position. Continued employment without professional training is undesirable and educational leaves which encourage the apprentice to complete professional training should be a recognized policy.

Thus this Committee strongly affirms that experience is not a substitute for professional training in the field of social case work.

2. *Case Work Supervisors.* The case work supervisor shall have had, in addition to a graduate degree in social case work, a minimum of three years' experience subsequent to professional training as a case worker, during which he has demonstrated more than ordinary competence.

3. *Chief Social Worker or Director of Social Service.* In addition to graduate professional training, he should have had a minimum of five years' experience, at least three years of which shall be subsequent to professional training, during which he has demonstrated ability as well as case work skill. At least two years of the five should have been in a supervisory capacity, and at least three years in a psychiatric setting.

Training of Students of Social Work

Where the social work staff is sufficiently large, is not subjected to the pressure of excessive case loads, and has personnel of supervisory calibre, the Committee recommends affiliation with accredited graduate schools of social work. Students should not be accepted for field work placement in a mental hospital until they have completed six months, or two quarters, of field placement in basic case work.

It is recommended that field placement in a mental hospital should not be less than nine months.

Social Work Staff Needs in Relation to Patient Population

There are no present criteria to determine the number of social workers who would be needed to carry out the practical job of providing patients with adequate case work services. Nevertheless, some attempt should be made to establish reasonable ratios to guide hospital administrators in determining the size of the social work department. The ratio of one psychiatric social worker to every 100 annual admissions suggested by the American Psychiatric Association is inadequate.

It is therefore recommended, on the basis of careful consideration, that there be a least one psychiatric social worker to every eighty new admissions per year; and *in addition* at least one psychiatric social worker for each sixty patients on convalescent status or in family care. Administrative and supervisory psychiatric social workers should be added in the ratio of one supervisor to every five staff case workers.

In conclusion, it is this committee's conviction that the establishment of the minimum psychiatric social work program herein recommended will result in better care for patients, decrease in length of patient stay, reduction in number of re-admissions and improved public relations.

Committee on Psychiatric Social Work
Marion E. Kenworthy, M.D., Chairman
Grace Baker, M.D.
A. Z. Barhash, M.D.
Jules V. Coleman, M.D.
Hyman S. Lippman, M.D.
Joseph J. Michaels, M.D.
Florence Powdermaker, M.D.
Lewis L. Robbins, M.D.
Harry Solomon, M.D.

Consultants to the Committee

Elizabeth B. Bech
Director of Psychiatric Social Work
Essex County Hospital and Mental Hygiene Clinics
Cedar Grove, New Jersey

Rowland Burnstan, Executive Director
State Charities Aid Association, New York

Hester B. Crutcher, Director of Social Work
State of New York, Department of Mental Hygiene
Albany, New York

Ethel Ginsburg, Consultant in Psychiatric Social Work
National Committee for Mental Hygiene, New York

Margaret Hagan, National Director of Hospital Service
American Red Cross, Washington, D. C.

Marian McBee, Executive Secretary
New York City Committee on Mental Hygiene, New York

Katherine C. Wickman, Psychiatric Social Worker
Psychiatric Clinic, Babies Hospital, Columbia University, New York

Jeanette D. Nadler, Psychiatric Social Worker
A. H. Wilder Child Guidance Clinic, St. Paul, Minn.

Myron John Rockmore, Director of Social Service
Treatment Center, N. Y. Psychoanalytic Institute, New York

Mildred Scoville, Executive Associate
Commonwealth Fund, New York

Charlotte Towle, Professor of Social Service Administration
School of Social Service Administration
University of Chicago, Chicago, Ill.

Grace Weyker, Psychiatric Social Worker
A. H. Wilder Child Guidance Clinic, St. Paul, Minn.

A GROUP DISCUSSION OF THE INTER-RELATIONSHIP OF PSYCHIATRY AND PSYCHIATRIC SOCIAL WORK

By EDITH BECK,* HELVI BOOTHE, M.S.S.† and LEWIS L. ROBBINS, M.D.‡

As part of the training program of the Institute for Psychological Medicine of The Menninger Foundation and Winter Veterans Administration Hospital, a series of eight seminars was held from January through March, 1947, for the purpose of discussing the inter-relationships between psychiatry and psychiatric social work. These seminars were attended by social workers and psychiatrists from both the Winter Veterans Administration Hospital and The Menninger Foundation.

Our experience in recent years in establishing social service departments in these institutions, as well as in teaching social workers and psychiatrists, indicated that there is considerable confusion about the role of psychiatric social workers within the hospital setting. There was vagueness as to basic case work concepts, their translation into the complex setting of the hospital, and the specific contribution of psychiatric social work to the clinical psychiatric team. An examination of the attitudes of the social service and psychiatric staffs of both Winter Veterans Administration Hospital and The Menninger Foundation indicated that they reflected the confusions which are extant in the field as a whole. Some felt that the contribution of psychiatric social workers was in doing "almost" what psychiatrists do, thereby meeting a need created by the shortage of psychiatrists and saving the time of the staff psychiatrists. Many psychiatrists saw the social worker useful only in terms of running errands, writing letters, etc., and had little understanding or acceptance of the social worker as a person offering a dynamic contribution in the treatment of the patient. It was felt that through the group process of holding seminars attended by both social workers and psychiatrists, a better understanding and clarification of the role of the psychiatric social worker in the hospital setting might be reached.

Coincident with the establishment of this seminar program a questionnaire was received from the Committee on Psychiatric Social Work of the Group for the Advancement of Psychiatry. This questionnaire (see page 188) formulated the same problems which had been encountered by our group, so that one of the ultimate functions of this seminar series was to attempt to answer the questionnaire of the Group for the Advancement of

* Chief, Social Service, Winter Veterans Administration Hospital
† Director, Division of Social Work, The Menninger Foundation
‡ Director, Out-patient Division, The Menninger Foundation

Psychiatry, which answers subsequently were incorporated in the thinking of the Committee on Psychiatric Social Work for the Advancement of Psychiatry in the report published in this *Bulletin*.

The seminar program was divided into a series of topics dealing with the activities of the psychiatric social worker in various phases of the hospital program. Social workers from both The Menninger Foundation and Winter Veterans Administration Hospital presented short papers dealing with their activities in their respective institutions, describing what they did, discussing what was done elsewhere and commenting about what they thought should be done in the particular phase of social work under discussion. Following the presentation of these papers, after a short question period, they were opened for discussion. Stenographic notes were kept and we are here presenting excerpts of the discussions, since it is felt that they may be of interest to our colleagues who are faced with similar problems in achieving integration of the clinical team for the maximum help to patients.

The first evening was devoted primarily to planning the seminar series and determining what areas most needed discussion. Although the discussion at this point seems scattered and desultory, there was good beginning movement in that the group got together on its general purpose, defined its problems, and worked out its method of procedure.

The second seminar revolved around the activities and functions of the psychiatric social worker at intake and reception and various technical points regarding administration and practice were brought up. Although there was no direct discussion of the role of the psychiatric social worker in the clinical team, the worker's contribution emerged more clearly as his use of basic case work skills was clarified. It was interesting to note at this point that the social workers moved together toward closer unity as they achieved a common denominator in their functioning, but that the psychiatrists were not yet at one with the rest of the group.

During the third seminar, when papers were presented on the topic of the contribution of the social worker to the diagnostic study of the patient, one of the basic questions of the entire series was raised. *Doctor "X"*, chairman of the seminar, stated: "I gather the impression that the social worker in both institutions (Winter Hospital and The Menninger Foundation) in many respects provides a service to the psychiatrists, obtaining historical data for him, which, if he were not so busy, he might just as well obtain for himself. I do not believe this is a correct concept and I feel we should discuss what is right in real as well as ideal terms. In other words, what is the unique contribution of the social worker during the diagnostic process which the social worker makes because of his specific training and skills? What is it the social worker contributes to the diagnostic study that

the psychiatrist is less well equipped to add? What is the social worker's unique contribution which is not ordinarily a part of the rest of the clinical investigation?" The confusions of both the psychiatrists and the social workers emerged sharply as the following excerpts from the minutes will demonstrate:

Doctor "Y": "I think that in certain areas which the social worker covers she does make a unique contribution, whereas in other areas she does not. The psychiatrist is just as capable of obtaining a history of inter-personal relationships from the family, but where the social worker shines would be in the areas in which the doctors are not trained, such as relationships in the environmental setting. The worker can check with the family, verifying the relationships of the patient to civic and fraternal things. I feel that the social worker maintains contact with the family, and I feel further that if the doctor has any contacts at all with the family they should be few. The patient must feel that the doctor is *his* man."

Miss "P": "There are not enough psychiatrists at the present time to take care of all the patients. If we had all the psychiatrists we needed, it is quite possible that they could obtain the social history themselves. Because of this lack of trained people the social worker does play an important part."

Doctor "Z": "The social worker should think sociologically in terms of cultural, economic and political relations. Personal relations lie in the realm of the psychiatrists."

The discussion continued around the following points: First, that of the difference between the psychiatrist and social worker being not one of kind, but rather one of focus and emphasis; and second, that such focus and emphasis constitutes a particular area of specialty; that there is not the time in one lifetime to learn thoroughly enough of all the specialties which are necessary to understand and help an individual; third, that although the psychiatrists and social workers both have their specialized areas and roles in helping the patient, there are other areas where their functions overlap, where one or the other may work with equal skill.

Miss "Q": "I think it is not a difference so much as a matter of emphasis and focus. Our focus is understanding the patient in relation to his living situation.

Miss "R": "The social worker focuses her attention on all the outside forces which have played on the individual instead of the intra-psychic forces."

Miss "T": "My point again is a matter of emphasis. I wonder if the doctor in coming to a diagnosis might not be looking more for pathology, whereas the social worker may be placing more emphasis on the factors of health in the patient as reflected in his living relationships in concrete performances."

Doctor "X": "The social worker employs a frame of reference in which the same areas may be discussed by her as by the psychiatrist, but as Miss "T" said, the

psychiatrist is likely to think primarily in terms of pathology, although he would not do so to the exclusion of all other areas. While taking a history, the social worker is especially concerned with or aware of the influences of the environment from which the patient came, and to which he will return. Instead of 'focus' one might better say 'pay special attention to'. While the psychiatrist, during his examination of the patient, may be following the regressions, fixations, etc., of the libido, he is not unaware of the social implications. The social worker is similarly not unaware of the effects of the instinctual drives, but is particularly listening to the environmental social influences. The social worker has skills which the psychiatrist could learn in time; at the same time, with additional study a social worker might become a psychiatrist. Instead of this prolonged educational process we call in experts and pool our knowledge and skills."

It is to be noted that as the discussion progressed the group moved toward a more dynamic understanding of the contributions of the psychiatrist and social worker, and there was some giving up of the competitive element. An attempt was made to clarify the question of what the unique contribution of the social worker is, but it was felt that this would emerge more specifically as the seminars progressed.

The next several sessions brought about more and more clarification of the activities of the social workers in the hospital setting. Particularly interesting were some of the conclusions reached during the seminar on trial visits, discharge and follow-up. The Winter Hospital worker stated in her paper that in her hospital it was an administrative procedure to see the patients on clearance before they left the hospital. Such an interview made it possible to catch some patients with social problems and make referral to the proper social agencies in the community. Questions brought out the fact that it was not possible to provide complete social service coverage for patients and that it was possible to have some kind of contact on at most fifty percent of the patients. *Mrs. "O"* formulated the problem as follows:

"I would say that the ideal is to have continuous contacts, making the so-called discharge interview the final interview in terms of total treatment. Because of pressures we may see problems while taking a history but not have time to do anything about them."

Dr. "Y" asked if there were resistance on the part of the doctors in referring cases to social service. The workers replied that the doctors were not resistive but that the lack of staff made it impossible to provide all the necessary social service and that, without sufficient staff, a continuous interpretation of social service function could not be made to the doctors.

Dr. "X" reminded the group that most doctors have little understanding of social service because they receive little or no information along these lines in the course of their education. He stated that it is being recommended that each medical school faculty include a social worker who will participate in the curriculum.

It was agreed that in a hospital setting the ratio should be a maximum of fifty patients to one social worker; preferably one social worker to each ward of twenty-five patients. When the ratio is higher it is the discharge and post-discharge planning that suffer most. Dr. "X" stated:

> "The hospital is dependent, to a large extent, on the social service department for maintaining continuous relations with the patients during their stay and after discharge from the hospital. If the workers cannot think beyond their daily duties and problems, they certainly cannot plan a continuity of thinking and planning with the patient."

In discussing the importance of follow-up it was pointed out that it was the only means of checking on the validity of the hospital's program, and the only way of determining the effectiveness of the social readjustment and health of the patient.

It was also stressed that the social worker maintains liaison between the hospital and the community and that follow-up creates good will in the community since it indicates the hospital's continued interest in its patients. This would lead to a better understanding of the kind of help the hospital is giving and make it easier for potential patients to accept hospitalization when necessary. The amount of security it gives to patients was also stressed.

The discussion returned to the importance of early post-discharge planning and it was agreed that if the social worker is called upon as soon as the doctor begins to consider discharge, the number of patient days might be appreciably reduced through the earlier resolution of environmental problems and more complete post-discharge planning.

This session was marked by the complete agreement of the doctors and workers that discharge planning and follow-up service were among the most important areas of social work help. There was no disagreement at any point; the social workers and psychiatrists were in complete unanimity.

From time to time the question of the psychiatric social worker in psychotherapy, was raised, and each time the issue was more or less skirted until there was a better understanding on all sides of the basic functions of the psychiatric social worker. In these sessions the psychiatrists moved to the point where they could better accept the importance of the social workers' relationship with the patient, and could see that relationship as purposeful in facilitating the psychiatrist's treatment of the patient. It is to be recalled that in a previous session *Doctor "Y"* felt that the patient's relationship should be with the doctor only, to enable the patient to know that the doctor is "his man."

The last three sessions of the seminar centered around the therapeutic activities of the psychiatric social worker and differentiation of the roles of the psychiatrist and the social worker in therapy.

Doctor "Y" immediately raised the question of how the public could be protected from untrained people performing psychotherapy. He asked:

"How are you going to differentiate between the social worker who has worked for a county welfare board, and one who has had considerable practice? It seems that psychiatry has too long been in the hands of all kinds of people. The public needs some kind of protection. If you limit psychotherapy to psychiatrists there at least has to be a minimal amount of training."

Doctor "X": "The limiting of psychotherapy to psychiatrists is not a law. The certification of psychiatrists is something that doctors have agreed upon among themselves, and has primarily prestige value. I grant that the public needs protection, but within that realm the mere requirement of a medical degree is no criterion for permitting any doctor to practice psychotherapy."

Mrs. "O": "A supportive treatment role is often successfully carried by the social worker, as, for instance, in the case of many ambulatory schizophrenics."

Doctor "X": "It is true that some of our sickest patients must be treated by non-expressive methods. Therefore, the question of the degree of severity of the illness apparently does not offer an area of differentiation between which patients may or may not be treated by psychiatric social workers. It may be that the question of differentiation between therapy by social workers and by psychiatrists may have to do with the intensity and/or depth of the therapy."

Mrs. "O": "I don't believe that supportive therapy is the only therapy that social workers are equipped to do. The primary interest for social workers is the patient's relationship to society. I do not think this means that the understanding of the personality structure as it comes out in therapy is outside of our domain."

Doctor "Y": "It boils down to the fact that you have to be able to handle all therapy or you shouldn't start. That is the implication I got."

Doctor "X": "Let us assume that it is common practice that prior to any therapy there is a study and evaluation of the needs of the patient, and that therapy is planned with the understanding of what one is going to do and what one is likely to encounter."

Doctor "Y": "Does therapy always go the way you plan it?"

Doctor "X": "I have attended conferences in which the original diagnostic study was presented after the treatment of the case had been concluded, and the original formulations checked with the experiences of the therapist who treated that case. It was found that our predictions were quite good. Therefore, I feel that the estimates of the need of the patient at the conclusion of a diagnostic study can be made with a reasonable degree of accuracy. After all, this is common practice in medicine. A surgeon, on the basis of his diagnostic study, may perform an appendectomy, and in the majority of instances find that his original diagnosis is confirmed. Obviously, of course, if he should begin an operation and discover that the patient is suffering from something other than appendicitis he must be

able to take care of this other condition or have available to him experts who can assist him if the problem is beyond his skills."

Doctor "Z": "What is it that a doctor can bring to a situation that others cannot?"

Doctor "X": "At this point I think it would be worth while to read to you a statement by Dr. Nathan Ackerman* regarding the qualifications of a therapist: 'It is possible to think of the problem of qualifications as involving mainly three factors: personality, training and experience. The first indispensable requirement is a suitable personality make-up. Suitability in this sense must include not only the emotional capacity to empathize with the patient and capacity for insight, but must be concerned also with questions of ego-stability and ego-integrity. Without these no amount of training or experience can create a psychotherapist. This issue applies to all classes of therapists in exactly the same way. Psychiatrists cannot be favored when the issue of suitability of personality is considered. Beyond that, the quality and extent of training and the type and amount of experience are of tremendous importance.'"

At this point the question of whether or not the social worker was equipped to recognize organic medical problems if they should occur in the course of treatment, was raised. In answer to this, *Miss "Q"* stated:

"A social worker has had medical background and there is an increasing sensitivity to it. From the point of view of training and experience it is possible for the social worker to catch symptoms and go on from that point."

Miss "W": "It is not true that the psychiatric social worker has no orientation to the medical problems which might occur. The worker may not know *what* is wrong but she can detect that *something* is wrong."

Mrs. "O": "No social worker would attempt to diagnose, but certainly sensitivity to organic disorders is part of the training of a social worker."

Doctor "Z": "If one is dealing with a person psychotherapeutically, one is still dealing with a mass of protoplasm which obeys certain biological and physiological laws, and the individual cannot divorce himself from operating according to these laws. Does a social worker, even though she is highly trained psychiatrically, have sufficient orientation in the way in which protoplasm works?"

Mrs. "N": "I cannot see how the social worker doing psychotherapy could very well proceed without medical help, inasmuch as the social worker does not understand the organism."

Doctor "Z": "My question is, can the social worker who is not oriented in biological concepts do a complete job?"

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* What Constitutes Intensive Psychotherapy in a Child Guidance Clinic. The Case Worker in Psychotherapy. *Published by the Jewish Board of Guardians.* Pp. 16-29.

Doctor "X": "The social worker today has an awareness of physical changes which affect emotional processes. I wonder if a physician treating a psychologically ill person can adequately treat that patient without a thorough knowledge of social dynamics, such as social workers have. Can either a physician or a social worker treat an individual without a thorough knowledge of psychology? I believe that it is true that a psychologist, psychiatrist or psychiatric social worker can be sufficiently conversant in the other two fields to recognize when there might be a feature in his case requiring the expert assistance of another member of the team."

Doctor "Z": "The question I raised was whether a thorough knowledge of biological factors which the physician has is essential to understanding psychological processes sufficiently to be a psychotherapist. It seems to me that a partial answer to this is derived actually in clinical practice; namely, that social and psychological factors seem to be more important than biological factors. If this is true, it is an interesting and challenging fact."

Mrs. "O": "I believe we answered previously this question by deciding that man was a psycho-bio-sociological unit, and that no one side of this triangle took precedence over the other."

Doctor "X": "There are some who believe that if we had a fundamentally different social structure that many psychological ills of human beings would disappear. We don't know whether social and economic factors are more important, or whether biological factors are more important. Here the value of the team work concept begins. I saw a patient recently who was a spastic schizophrenic. His spasticity may have had something to do with his becoming a schizophrenic. Other spastics have had protection in their homes and have not been subjected to the same type of experiences that this patient was. The patient was rejected in favor of a younger, healthy sibling; thus, it became a family social problem. If the patient had not been a spastic he probably would not have been rejected and may not have become a schizophrenic. Now the question is which is more important? In the present state of our knowledge we have to study this person from all sides. No single orientation could successfully complete the job of understanding this patient. I do not feel the doctors will ever fully understand emotions from a purely biological approach. The social worker brings into the picture something that the physician from his biological orientation does not ordinarily bring in, and therefore has a role in every one of the phases of psychiatry, including research, treatment and prevention. It seems to me that some social workers might become particularly proficient in certain phases of their total social work field and thus create specialties, one of which might be psychotherapy."

Doctor "Z": "I wonder if it would help if some of the people here would tell us what cases they feel comfortable in treating."

Mrs. "O": "I have a few not well formulated notions about this. I would say that I don't feel comfortable in treating cases where the entire focus is on the internal dynamic disturbances. I feel more comfortable if I can consider the person in relation to his environment at the beginning point and then meet the patient's needs. If you ask the question in regard to diagnostic categories I

think it is difficult to answer. Although ambulatory schizophrenics are very taxing and require a tremendous amount of patience I do not feel less comfortable with them than with other patients. I think, rather, that the answer to your question has to be given in terms of levels of therapy."

Miss "Q": "I would agree with what *Mrs. "O"* has said. I don't think the psychiatric social worker is equipped to work on the unconscious levels."

Doctor "X": "I think it is important to recall that one of the things that is definite is that a doctor who meets the minimum requirements for certification as a psychiatrist, has usually far beyond the minimum requirements that the social worker has in the field of psychotherapy. Until recently the field of social work has provided little training in psychotherapy. At The Menninger Foundation social workers have come and worked under supervision, attending staff conferences, etc. As they acquired more skill they were allowed to work with more difficult cases, under supervision of the psychiatrists."

Doctor "Y": "For the past several hours in these seminars we have been discussing the many activities of the psychiatric social worker and have recognized that the number of social workers available are too few to adequately conduct these. If the social worker is also going to act as a psychotherapist, when can she get everything else done?"

As the discussion continued there was general agreement that given the personality, training and experience a social worker could function as a psychotherapist under the supervision of a trained psychiatrist. It was pointed out that the primary interest of the social worker is the patient's relationship to society. However, in working with the patient's social maladjustments the need of the patient might lead into his deeper conflicts. Since personality is the result of the inter-action of the individual with his milieu and since the social worker and the psychiatrist both have the ultimate objective of helping the individual with his social adjustments there will be many things that the social worker and the psychiatrist do in common, even though they begin at different points. The social worker begins with the patient's social maladjustment which may lead to the treatment of his inner conflicts. The psychiatrist may focus on the intrapsychic problems and find it necessary to work with the patient's social environment.

The seminars concluded on the following note: Man is a complexly inter-related biological, sociological and psychological entity. When he becomes ill and is unable to function the total person is involved. The treatment of the individual rests on three pillars: biology, sociology and psychology, and in order to help him we must, in addition to the knowledge and skills of our own particular disciplines, have an awareness of the others so that we may call upon them in order to provide maximum help for the individual. Each discipline, psychiatry, clinical psychology and social work has its own extensive body of knowledge and skills. One lifetime

would not be sufficient to learn enough of all three for one person to be of proper help to the sick and maladjusted. We therefore specialize in one of these disciplines, secure some knowledge and awareness of the others and call upon other experts to work with us in an integrated manner in the treatment of the sick. This is the way in which the clinical team operates; the psychiatrists, social workers, and clinical psychologists coordinating their knowledge and skills toward a common purpose—that of helping people to get well and be useful contributing members of society in a manner which will bring them positive satisfaction.

Although there was considerable clarification of problems and functions, there were still many areas for future study and investigation left at the end of this seminar series. There were several areas in relation to the functioning of the clinical team which were not discussed at any length. However, clarification of the respective roles of psychiatry and psychiatric social workers did begin to emerge. It is to be noted that the first sessions were devoted to a clarification of basic case work help within the framework of a hospital. When these were clear the discussion went into the disputed area of psychotherapy. However, by this time the group was no longer looking for well marked out areas in a patient around which a fence marked "Psychiatrist," "Social Worker," with "Keep Out" signs, could be put up. The patient and his needs became the focus. The particular area of the social worker's contribution was defined and the qualifications for the practice of psychotherapy, both for social workers and psychiatrists, were set down.

It is felt that both from the administrative and teaching level the seminar had considerable value. It enabled us to see more concretely what our teaching problems were, both for the social worker's staffs as well as for the psychiatrists. Furthermore, it brought out concretely some of the problems involved, in translating the concept of the clinical team into a functioning reality.

THE DEVELOPMENT OF A SOCIAL WORK PROGRAM AT WINTER VETERANS ADMINISTRATION HOSPITAL*

By EDITH BECK†

The Social Service Section of Winter Veterans Administration Hospital is now in its second year. We began our existence in the spring of 1946, a new service in a newly established Veterans Administration Hospital. We struggled to establish our identity, a small unit, with its own professional separateness, yet closely inter-related with the complex, dynamic development of the hospital. We have developed our program and defined our function; we have achieved some clarification of the role of the social worker in the clinical and hospital team; we have worked out our major relationships with administrative departments, as well as medical sections in the hospital; we have worked with community agencies and secured excellent cooperation in meeting the social problems of patients and their families. We have worked out a program for students from schools of social work, for their field placements in psychiatric social work. This development was directly related to our primary responsibility to our patients. We have been of help to many patients and their families, help which was given under many pressures and in the face of problems and confusions.

I think that first it might be well to review the general characteristics common to all hospitals and then the particular features of Winter Veterans Administration Hospital. It is an accepted principle in our casework practice that the social worker functions within the particular structure of the agency in which he works, that the casework help he gives to a patient or client is determined by and focused around the specific purpose for which the agency is set up. Therefore, in order to understand our casework practice in a hospital, we need first to understand the structure of the hospital.

A hospital is a small community with a protected and controlled environment, set up for the treatment of those who are too ill to be treated at home, or for whom medical care is not available in their living situation. Society, on the whole, sees the hospital as a social institution which gives medical care to the very sick, with acceptance of the fact that death is a possibility for some patients in spite of the best medical care which the hospital provides. Illness and hospitalization, therefore, may precipitate for the

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† Chief, Social Service Section, Winter Veterans Administration Hospital

patients and relatives, fears and anxieties, conscious and unconscious, of varying degrees.

A mental or psychiatric hospital brings to it its own particular social attitudes which have a long, historical past. Mental illness is still looked upon by many elements in our culture as an offense against society. The community meets the aggression of the mentally ill by hospitalization, for its own protection primarily, rather than for the medical treatment of the sick. It precipitates deep seated fears in relatives through the traditional fear that the "taint" is in the blood, and may some day be visited upon them. The psychiatric or mental hospital has less status in the community than the general medical hospital, and is frequently viewed as a house of detention.

Winter Veterans Administration Hospital, like all hospitals, has these elements in its structure. In addition, it has its own specifics. It is established and maintained by the United States Government for the medical care of veterans who need hospitalization. The veteran is a citizen who has served in the United States Armed Forces during a period of war and this experience constitutes his specific difference from other citizens in the country. This experience brings with it its own psychological concomitants.

Winter is a 1400 bed government hospital for veterans. About half of the beds are occupied by patients under treatment for psychoses, and severe neuroses; the other half by patients with medical, surgical, psychosomatic and neurological conditions. The hospital is set up for the treatment of patients having acute conditions rather than for the treatment of long-time chronic conditions. The average turnover of the patient population is 40% per month.

Institute of Psychological Medicine

There is an additional function of the Hospital in that it has been authorized to serve as a psychiatric training center for psychiatrists, psychologists, social workers, nurses, and psychiatric aides. The Menninger Foundation was asked by the Veterans Administration to participate in this development and Dr. Karl Menninger took over its leadership as well as becoming manager of the Hospital. The planning and coordinating body for this training has been named the Institute of Psychological Medicine.

The four professional disciplines directly concerned with the treatment of patients are organized as distinct training units under the Institute, and are known as the School of Psychiatry, School of Clinical Psychology, School of Psychiatric Nursing, and the Division of Psychiatric Social Work. Each unit has its own executive committee, with a representative

from each of the other units, which is responsible for the development of the training program within its own profession. Staff members of Winter Veterans Administration Hospital and The Menninger Foundation constitute its faculty. The social service chiefs at The Menninger Foundation and at Winter Veterans Administration Hospital are both on the Institute faculty as Associates in Psychiatric Social Work. The Social Service Chief at The Menninger Foundation was appointed consultant by the Veterans Administration to the Social Service Section at Winter Veterans Administration Hospital.

The resources of The Menninger Foundation which include the sanitarium, out-patient clinic, and Southard School, and those at Winter Veterans Administration Hospital are utilized as placements for the resident psychiatrists, internes in psychology, student nurses and social workers, where they practice under supervision. Lecture courses, seminars, individual and group controls on treatment, and guest lecturers brought to the hospital because of their special contributions, are also part of the planned educational program of the Institute. The lectures and seminars in the training program of any one school may be attended by the others, if they meet the training needs of their own students or staff. This avoids duplication and achieves a unity within the entire educational and training program. In its structure and its method of operation, the Institute of Psychological Medicine represents the optimum in the concept of the clinical team.

The full extent of our responsibility emerged simultaneously with the total training program in the hospital. In the beginning, we saw as our major training responsibility the interpretation of social work help to the residents. We were called upon to give orientation lectures on social work to nurses, aides, volunteers, and other groups in the hospital. In April 1947, we were scheduled to give a course of lectures to the psychiatric residents on the Inter-Relationships of Psychiatry and Psychiatric Social Work. The full measure of our gains from the training program is difficult to evaluate, since inherent in our learning process is our interaction with the hospital, of which the psychiatric training program is an indivisable part. However, on a planned level there was focus and direction. We utilized the hospital program in the development of our staff although here, too, we were feeling our way. The social workers attended the clinical conferences on their own sections and the large, weekly, clinical conferences in the hospital. They also attended evening seminars on topics of particular interest to them, and the monthly forums which have outside guests as speakers. We arranged a three month course for our staff on the Dynamics of Personality and Its Deviations. Our problem was to assimilate and to use our increasing understanding of personality

and diagnosis to further our own professional development as caseworkers. Through our own staff meetings, seminars, and supervisory conferences, we worked toward the translation of the psychiatric concepts we were learning into case work practice.

This past summer, with our accumulated experience of the year, and with the formation of the Institute of Psychological Medicine, we were able to begin more concrete planning for the in-service training program of the social work staff, related to their professional developmental needs. In July 1947, Dr. Karl Menninger appointed the Executive Committee of the Division of Psychiatric Social Work of the Institute. This committee consists of one of our chiefs of neuropsychiatry, our Assistant Chief of Medicine, our Chief of Psychology, the Social Service Chief of The Menninger Foundation, and the Social Service Chief at Winter Veterans Administration Hospital who is chairman. The Manager and the Clinical Director of the Hospital, and the Director of Education of the Institute, are ex-officio members. In the composition of this committee, we have again the clinical team.

The function of the Executive Committee has been defined as having responsibility for planning and implementing the training and educational program of social service in Winter Veterans Administration Hospital in the following areas:

1. The training program for social work students.
2. The in-service training program of the social work staff.
3. Teaching and interpretation of social work to other groups in the hospital.
4. Consideration of the problems of integration of social work with other departments and with the program in the hospital.

Training and Field Placement for Students

In September, 1947, eighteen social work students began their field work placements at Winter Veterans Administration Hospital, twelve in their second year field placements and six advanced students in their third year field placements. This training program for students is the culmination of a year's joint planning between the Veterans Administration and The Menninger Foundation, through the over-all training and educational structure, the Institute of Psychological Medicine. Of the twelve second year students, six came from the Smith College School of Social Work (Northampton, Massachusetts), and six from the George Warren Brown School of Social Work, Washington University (Saint Louis, Missouri). The six advanced social work students came from the School of Social Work, University of Pittsburgh, and are working toward their doctorate in social work. This advanced program was initiated by the School of

Social Work of the University of Pittsburgh, and is open to social workers with a M.S.W. who have had three to five years of good experience, preferably in a medical or psychiatric setting.

The training of social work students is an authorized part of the program of the Veterans Administration. The standards, regulations, and procedures have been specified in Veterans Administration circulars. Schools of Social Work interested in the facilities of the Veterans Administration initiate their contacts with the Social Service sections of the Veterans Administration on a national and branch level. The specifics of the training program are then worked out between the school of social work and the station where the students are receiving their field instruction, and they maintain contact with each other on a continuous basis. The Branch Social Service Chief keeps in close touch with the development and progress of the training program for social work students within the branch stations.

Plans for field placements of both the second year and advanced students have been worked out. The Closed Wards and Medicine and Surgery have been selected as the training sections for the students, to which they will be assigned and where they will get their practice. With the second year students the primary emphasis will be placed on their case work practice. They will be supervised by well qualified supervisors who have been appointed to the Social Service staff at Winter Veterans Administration Hospital. Special case work seminars are planned for them, focused on the translation of the psychiatric concepts which they are learning into case work practice. Didactic courses, clinical conferences and other training facilities set up by the Institute of Psychological Medicine will be utilized in the training when they are related to the case work practice of the second year students.

The training program for the advanced social work students from the University of Pittsburgh will include, in addition to their practice on the sections, an intensive didactic program. They are supervised by Miss Eleanor Cockerill, Professor of Social Work, University of Pittsburgh, in residence at Winter Veterans Administration Hospital. These students came to the hospital in September for a month's orientation, returned to the Pittsburgh campus for a three months period of intensive didactic seminar work, and will come back to Winter Veterans Administration Hospital in January, 1948, for an 8-month period of field instruction and concurrent advanced seminars. They will attend some of the didactic courses set up by the School of Psychiatry of the Institute for its resident psychiatrists, and taught by the faculty of the Institute. Some of these courses will be on The Structure and Development of Normal Personality, Dynamics of Psychiatric Syndromes, Child Psychiatry, Psychiatric Treat-

ment, Social Psychiatry, and Clinical Psychology. They will also have advanced seminars in case work practice, teaching, supervision, and administration. In addition to Miss Cockerill, the instructors for these seminars will be members of the Social Service staffs at The Menninger Foundation and Winter Veterans Administration Hospital, who are on the faculty of the Institute of Psychological Medicine.

This training program has been so planned that it will be an integrated part of the Social Service section at Winter Veterans Administration Hospital.

A Growing Service

We might next indicate briefly how we developed social work help for our patients, what problems we faced, how we met some of them, and where we are now. As the social service section began to function, it was faced with the many problems of a beginning process. It was necessary to organize the department, set it up administratively, to give it form and structure. Good inner organization is basic to good social work performance. The social workers have their offices on the sections to which they are assigned, removed from each other and from the administrative offices. We had to integrate the professional and clerical staffs, so that the entire social service section could operate as a coherent, effective unit.

It was necessary for us to work out relationships with other departments in the hospital, to define and clarify the areas of our respective administrative responsibilities.

We had to give a professional service in a complex setting, seriously handicapped by understaffing and resultant overwhelming pressures. We had to define our own professional role in this setting so as to be a contributing member of the clinical team. We had to mobilize the community resources, and secure their cooperation, in the social planning for our patients and their families.

We began to work immediately on our administrative structure. We discussed in our staff meetings the mechanics, routines and procedures. We set up case registers, card and case files, routines for opening, closing and transferring cases, worked out the organization of our social case-work records, established dictation schedules, defined the administrative aspects of the social worker's job, etc. Representatives from the clerical staff were invited to the meetings of the professional staff, and problems common to the functioning of both were discussed. We attained integration of the social service section through staff participation, sharing problems and, together, working out some of the answers. Clarification of generic case work concepts and practice, and their use in a hospital setting, was basic to our professional development and our effective functioning.

Our pressures were definitely related to the realities of understaffing. We had a beginning staff of eleven social workers, and with the most highly developed case work skills, they could not have met the social work needs of our patients on a minimally adequate basis. The pressures on a social service staff in a hospital must be seen in light of the additional responsibilities which are inherent in a hospital setting. The hospital is the patient's immediate living environment and the social worker is always accessible to him. If he is upset, he does not wait for his scheduled appointment, but brings the worker his immediate problem, often related to his daily living situation on which he may have displaced anxieties from other sources. It is not possible to adhere closely to a planned schedule. There are interruptions not only from the patients, but from doctors and others concerned with the treatment of the patients. In addition to being concerned with the patient's interaction with his hospital environment, the social worker also carries responsibility for the patient's relationships with and problems in his home community. It might be added that the maximum caseload for the social worker in a private agency, for effective service to clients has been set at thirty. The discrepancy between this standard, and the individual caseloads of many times thirty, for which many hospital social workers are held responsible, is too obvious for comment.

We attempted to meet this problem of pressures on two levels. One was administrative, that of securing additional staff. After discussion with our Manager, Clinical Director, and Branch Social Service Chief, the Social Service Chief at Winter Veterans Administration Hospital prepared a statement of "justification," requesting a social service staff of twenty-eight professional workers. In April 1947, we were granted a ceiling of twenty-seven social workers, and a proportionate number of clerical staff. This enabled us to plan an average of three to four wards per social worker, bringing down the caseloads to 100–125 each.

While we were waiting for a decision on our request for increased staff, we had to meet the pressures of the daily job as well as we could. We assigned our social workers to all of the sections in the hospital, since we could not select any one section as having precedence over any other in terms of need. We had to set limited goals, and the objective of maximum case work help in every interview we had. We learned that considerable help could be given in a single interview. This emerged clearly in our admission interviews, which are the first impacts of the patient and his relatives with the hospital. Considerable help has been given in alleviating the fears and anxieties which they bring to hospitalization, and in assisting with the social problems which hospitalization has precipitated in their homes.

We can also give help to many patients in our discharge interviews. It is

one of the administrative procedures in the hospital for every patient to be cleared through social service before he is discharged. Complete coverage of patients by social service was not possible, and this procedure provided a terminal interview with each patient. We evaluated with the patient his feelings about his hospitalization and treatment; helped the patient with any anxieties he might have had about leaving the protected setting of the hospital and returning to the pressures of the normal community; we referred the patient to the social agency in his community whenever need presented itself for social planning and a supportive relationship to facilitate the patient's readjustment in the community.

Progress

The progress which our Social Service section has made has been in the professional, as well as the administrative area. Through the continuous educational process which goes on in the hospital, our social workers are constantly learning more about the dynamics of personality, diagnosis, and interpersonal relationships. We are gaining more insight into the dynamic significance of environment and its therapeutic use in the treatment of the patient, both in the hospital and in the community. We are beginning to see with increasing clarity the contribution which the social worker can make.

We have become aware of many dynamics in our relationships with others on the hospital staff which directly affect the treatment of the patient. There are many difficulties involved in becoming an effective member of the clinical team. We have developed an awareness of the nurses and aides as essential members of the clinical team, but are only at the beginning of learning how to work with them in an effective, integrated manner. We have begun to examine our own feelings and attitudes as social workers towards our colleagues and have learned that some of us find it difficult to share the treatment of the patient with others. Our own satisfactions are frequently tied up with our being possessive of the patient, in maintaining the sole significant relationship with him, in being in complete control. It takes a high degree of maturity to place the patient's treatment above our own personal needs and to find satisfaction in the fact that the patient progressed because a number of the professions contributed their specialized knowledge and skills to his treatment.

From the knowledge gained during approximately a year's experience in the operation of our social service section, we worked out a statement of the function of the social worker in Winter Veterans Administration Hospital for the hospital staff. This gives specifically our responsibilities on reception, in assisting with the diagnostic study, in continuous treatment, in trial visits and discharge planning, and in follow-up. It

defines our administrative responsibilities as distinct from those which are in the areas of the medical department and various administrative departments. It defines the methods of referral to the social worker. However, because of limited space, only the general, introductory statement is given here:

'The social worker at Winter Veterans Administration Hospital, as a member of the clinical team, contributes, on referral, to the treatment of the patient in the hospital, securing and evaluating the social, economic and cultural factors of the patient's background which are of significance in understanding the patient and his illness; evaluating the patient's current social environment to which the patient will return on his discharge; helping the patient with his anxiety-producing reality problems, both in relation to himself and to his family; mobilizing the resources in the patient's community so that they will be of maximum help to the patient and his family during his hospitalization and permit him maximum adjustment when he returns home. The social worker also offers the patient a supportive relationship and casework help with his problems during his hospitalization."

Conclusion

In conclusion, I want to say that the past year was the beginning of our growth. Although we achieved clarity, security and unity in our own profession as well as with the other professions, we still have many problems to meet, much professional development to attain, and much to achieve in order to meet our responsibilities to our patients in giving them a highly skilled casework service, coordinated with the clinical and hospital teams.

BOOK NOTICES

Psychology for Nurses. By BESS V. CUNNINGHAM. Price $3.00. Pp. 336. New York, D. Appleton-Century Co., 1946.

The author of this book has taught psychology for some time to many groups of nurses and has a good approach to the subject, though at times her chapters seem to get a little out of hand and attempt to cover a vast amount of material in a small space. She states quite frankly that her main interest is in psychology and skirts the subject of psychiatry. There is a brief chapter entitled "Reaction to Strain and Frustration," wherein she speaks of "insanity," and brief paragraphs on schizophrenia and manic depressive states. This might lead the intellectually curious nurse to further reading on the subject.

Miss Cunningham covers the field of psychology fairly completely, if briefly, and there are excellent references for the reader who wishes to delve more deeply into specific branches. The writing is simple with an avoidance of technical terms. (Olga Weiss).

Modern Woman: The Lost Sex. By LUNDBERG, FERDINAND, M.D. AND FARNHAM, MARYNIA F., M.D. Price $3.50. Pp. 497. New York, Harper and Brothers, 1947.

The general purport of this book is that of the early chapters of *Love Against Hate*—namely, that civilization tends increasingly to frustrate women and to impel them to assume unsatisfactory and unnatural roles with resulting disappointment to themselves and displaced frustration of their children. Some of the cases selected, particularly the study of Mary Wollstonecraft, are extremely interesting even if not always conclusive. Curiously enough, in spite of an excellent bibliography and many footnote annotations with references, *Love Against Hate* is nowhere mentioned. (K. A. M.).

The Mind and Death of a Genius. By DAVID ABRAHAMSEN. Price $3.00. Pp. 228. New York, Columbia University Press, 1946.

This psychologic study of Otto Weininger's life and work, Dr. Abrahamsen documents in detail. Of particular interest are two letters (4, 13) from Freud, who read through the first version of Weininger's manuscript, "Sex and Character." Weininger constructed his book upon ideas about bisexuality which he got indirectly and inaccurately from him, Freud writes. (B. E.).

Problems in Religion and Life. By ANTON T. BOISEN. Price $1.50. Pp. 159. New York and Nashville, Abingdon Cokesbury Press, 1946.

Subtitled "A Manual for Pastors," Dr. Boisen's book presents a valuable study-and-conference method for orienting the clergy to the social and individual needs of their local community. Questionnaires are provided for the study of the community as a whole, its homes, typical individuals and special problems of personal and group significance. Each questionnaire is followed by an outline for a conference between ministers and with other professional workers to evaluate the findings and the effectiveness of relig-

ious work in meeting the needs. The areas of individual and group maladjustment are given careful attention. Some of the findings of Dr. Boisen's own research are indicated in "propositions for consideration" which are intended to provoke thought. The book reflects well his many years of experience in religious social survey, pioneering in mental hospital chaplaincy, teaching in theological schools and exploring the pertinent literature. (Chaplain Robert Preston, Winter Veterans Administration Hosp.).

An Essay on Morals. By PHILIP WYLIE. Price $2.50. Pp. 204. Rinehart & Company, Inc., 1947.

Because I considered the "Generation of Vipers" an extremely provocative book, I looked forward with pleasure to reading this new one by the same author.

I was prodigiously disappointed. It essays to be a presentation of the principles of Jung; it succeeds in being more confused and even more inconclusive than anything Jung ever wrote. (K. A. M.).

Aphasia: A Guide to Retraining. By CAPTAIN LOUIS GRANICH. Price $2.75. Pp. 108. New York, Grune and Stratton, 1947.

Captain Granich is one of a number of military psychologists called upon to work with and help aphasic patients relearn to understand and speak and write again. To this task he brought a valuable background of experience as a school psychologist for the New York City Board of Education. His book is based on a survey of about 300 brain-injured soldiers, a third of which had aphasia or related symptoms, and on intensive experience in the retraining of 38 cases with severe disabilities. It is well documented clinically by a brief but detailed account of the retraining of 8 of these patients. The manuscript was reviewed by both Kurt Goldstein and J. M. Nielsen, and is a factually reliable and instructive little volume. It will give most useful service as a working manual to clinical psychologists with limited experience in speech disorders generally and aphasia particularly, and to speech therapists and teachers confronted with practical problems of retraining. (Walter Kass).

Clinical Psychology. By C. M. LOUTITT. Price $4.00. Pp. 661. New York, Harper & Brothers, 1947.

The author presents a detailed account of the clinical application of behaviorist principles. The book, dealing exclusively with problems of childhood maladjustment, includes a discussion of the following topics: personality disorders, speech difficulties, remedial teaching, and problems relating to retardation and organic disease. Where no organic, intellectual or hereditary defects are found, discussion of etiology is limited to faulty training and to "vile environmental influences." Loutitt does not attempt to develop an integrated theoretical framework of the nature of normal development and maladjustment in children. He seriously questions diagnosing psychoneuroses and psychoses in children, but he omits discussion of the problem because "the frequency is so small that it is hardly of the same order of magnitude as the problems discussed," examples of which are fear, daydreaming, and withdrawn behavior. (Sarah Schafer).

Textbook for Psychiatric Attendants. By LAURA W. FITZSIMMONS. Price $3.50. Pp. 332. New York, Macmillan, 1947.

In a simply written, descriptive, non-technical book, we have an entire course and outline for psychiatric aides. The two, well made divisions contain an introduction to psychiatric nursing and its problems with simple descriptions of the more common psychiatric disorders and general nursing care, and specific chapters on treatment and procedures, definitions and explanations. There is a list of reference reading with wide range of good texts, and an excellent index. This book is written simply, without being patronizing, and stresses the patient as a person, and the attendant as an important functioning member of the psychiatric hospital staff. Because of its stress on the attendant as an intelligent and valued person in hospital life this text is an excellent one for all psychiatric institutions. (M. O. W.).

Ritual: Psychoanalytic Studies. By THEODOR REIK. Price $5.00. Pp. 367. New York, Farrar, Straus and Company, 1946.

This book, although first published twenty-seven years ago, remains one of the outstanding contributions in applied psychoanalysis. Dr. Reik bases his investigations on the theories evolved by Freud in "Totem and Taboo." The author assumes that the heuristic premise of the primordial guilt of killing the father of the primeval horde, the ensuing remorse, and ambivalence, have a universal validity in the history of mankind. Whether the stipulated sequence of events in the life of prehistoric man can be verified or not, the value of this book lies in its brilliant demonstration of how psychoanalytical knowledge of the "primary process" of thinking facilitates the elucidation of social, ethnological, religious etc. phenomena. Dr. Reik investigates the "couvade" of the primitives and also different puberty rites. In the analysis of the significance of blowing the ram's horn (shofar), the song "Kol-Nidre," the Moses legend, the author exemplifies the insufficiency of descriptive or historical methods. It is a fascinating book and ought to be obligatory reading for everybody interested in psychology. (Jan Frank).

The Case Worker in Psychotherapy. By STAFF MEMBERS OF THE JEWISH BOARD OF GUARDIANS. Price $0.50. Pp. 49. New York, Jewish Board of Guardians, 1946.

In the early thirties under Dr. John Slawson as Executive Director and Dr. Johan H. W. Van Ophuijsen as Chief Psychiatrist of the Jewish Board of Guardians, a major reorientation of the relationship between case work and psychiatry took place.

This monograph contains several articles, describing historically the gradual changes from the traditional psychiatrist, psychologist, social worker relationship to a newer type of Child Guidance service which uses the psychiatric social worker as the psychotherapist. The Jewish Board of Guardians, accepting the effectiveness of their new program, recognize at the same time they have had to overlook many prejudices in the field of psychiatry. The monograph outlines the present program giving details of the new relationship between psychiatrist and case worker and presenting several case illustrations. (Annette Renaud).

The Ego and the Mechanisms of Defense. By ANNA FREUD. Price $4.00. Pp. 196. New York, International University Press, 1946.

This is the first American edition of Anna Freud's classic contribution to the psychoanalytic study of ego function. It is an exact reproduction of the first English translation of this work published ten years ago in England. It is one of those pioneering studies which fast become and long remain standard text in this field. (Margaret Brenman).

Insight and Personality Adjustment. By THERESE BENEDEK, M.D. Price $4.00. Pp. 307. New York, The Ronald Press Company, 1946.

This book by Doctor Benedek is one of the outstanding contributions made thus far to the understanding of the psychology of citizens and soldiers during and after the recent war. Unfortunately, Doctor Benedek has chosen the title, "Insight and Personality Adjustment" and has used as a sub-title, "A Study of the Psychological Effects of War." This latter title should have been the primary title of the book as the entire text is really devoted to this topic.

This work is a very excellent and thorough study of the effects of war upon the total community, and specifically upon the members of the entire family constellation. It deals with the emotional reactions of soldiers, their parents, siblings, wives and children, as the soldier goes to war, is in the war itself, and upon his return. Doctor Benedek's observations and conclusions are all very clear and logical, and the entire book is written in such a readable and understandable manner that altogether, its qualities make it an outstanding work. All those who are interested in the problems of veterans and their families, should read this book and become thoroughly familiar with it. Although the book is directed primarily to social workers, counsellors, teachers and others of this general group, it is a worthwhile book for a psychiatrist, as well as anyone else who is concerned with the problems of veterans. (Lewis L. Robbins).

The Psychoanalytic Study of the Child. Volume II. ANNA FREUD ET AL (EDITORS). Price $7.50. Pp. 424. New York, International University Press, 1946.

This volume rises steeply above the level of the first volume which preceded it by about one and a half years. With very few exceptions the papers are of high quality and are well written. They cover a wide range of subjects, from theory and speculation to clinical and educational problems. It yields an impression of the wide applicability of psychoanalytic thought to the phenomena of childhood which can hardly be surpassed.

While most of the papers are in the field of "applied psychoanalysis" in the sense that they employ the accepted theoretical structure to elucidate the objects of research, there is one paper that appears to open up new vistas. It is E. H. Erikson's "Ego Development and Historical Change," a long, but not too long, paper in which an abundance of ideas and observations has been compressed.

The list of contributors to the volume is highly representative of the well known workers in the field. One wishes, however, that scientific contributions would be forthcoming from the younger generation of analysts as well. (Paul Bergman).

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